APPENDIX O-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Use original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use black or dark blue ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions. Samples of the HFS 1443 Provider Invoice, and the HFS 2803 Optical Prescription Order, may be found on the Department's Web site at: http://www.hfs.illinois.gov/medicalforms/

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of provider services.

COMPLETION		**ITEM EXPLANATION AND INSTRUCTIONS**
Required	**1.**	**Provider Name** - Enter the provider's name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the National Provider Identifier (NPI) number.
Conditionally Required	**3.**	**Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Not Required	4.	Role – Leave blank.
Not Required	5.	Emer - Leave blank.
Not Required	6.	Prior Approval – Leave blank.

Optional	**7.**	**Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider errors. If the address is not entered, the Department will not attempt corrections.
Conditionally Required	**8.**	**Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 23 (Service Sections) is other than 11 (office).
Optional	**9.**	**Provider City, State, ZIP** - Enter city, state and ZIP code of provider.
Not Required	10.	Referring Practitioner Name – Leave blank.
Required	**11.**	**Recipient Name** - Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the Department. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.
Required	**12.**	**Recipient Number** - Enter the nine-digit number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do **not** use the Case Identification Number.
Optional	**13.**	**Birth Date** - Enter the month, day and year of birth of the patient as shown on the Identification Card or Notice issued by the Department. Use the MMDDYYYY format. If the birth date is entered, the Department will, where possible, correct claims suspended due to recipient name and number errors. If the birth date is not entered, the Department will not attempt corrections.
Not Required	14.	H Kids - Leave blank.
Not Required	15.	Fam Plan - Leave blank.
Not Required	16.	ST/AB - Leave blank.
Required	**17.**	**Primary Diagnosis Description** - Enter the primary diagnosis that describes the condition primarily responsible for the patient's treatment.

Required	**18.**	**Primary Diag. Code** – Enter the specific ICD-9 CM, or upon implementation, ICD-10-CM code without the decimal for the primary diagnosis described in Item 17.
Required	**19.**	**Taxonomy** – Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5.
Optional	**20.**	**Provider Reference** - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.
Not Required	21.	Ref Prac No. – Leave blank.
Not Required	22.	Secondary Diag Code – Leave blank.
	23.	**Service Sections**: Complete one service section for each item or service provided to the patient.
Conditionally Required		**Procedure Description/Drug Name, Form, and Strength or Size** - Enter the description of the service provided or item dispensed.
Required		**Proc. Code/NDC** - Enter the appropriate CPT or HCPCS code.
Conditionally Required		**Modifiers** – Enter the appropriate two-byte modifier for the service performed. The Department can accept a maximum of 4 two-byte modifiers per service section.
Required		**Date of Service** - Enter the date the service was provided. Use MMDDYY format.
Required		**Cat. Serv.** - Enter the appropriate two-digit category of service code. 03 – Optometric Services 45 – Optical Supplies
Conditionally Required		**Delete** - When an error has been made that cannot be corrected, enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.

Required

Place of Serv. - Use the Place of Service code appropriate for the particular service. These Place of Service codes may be obtained from:
http://www.cms.hhs.gov/medhcpcsgeninfo/

Not Required

Units/Quantity – Leave blank.

Not Required

Modifying Units - leave blank.

Conditionally Required

Third Party Liability (TPL) Code – If the patient's Identification Card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL code as listed in the Chapter 100, General Appendix 9. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Section 25.

Spenddown – Refer to Chapter 100, Topic 113 for a full explanation of the spenddown policy. The following examples provide additional information:

When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal), attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form HFS 2432 shows a recipient liability greater than $0.00, the service section should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	The actual recipient liability as shown on Form HFS 2432
TPL Date	The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

If Form HFS 2432 shows a recipient liability of $0.00, the service section should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Conditionally Required

Status – If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is 000 or blank.

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party adjudication pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
10 – Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

TPL Amount – Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other status codes, enter 0 00. If there is no TPL code, no entry is required.

Conditionally Required

TPL Date – A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Status Code	**Date to be entered**
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432, Split Billing Transmittal
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Not Required

24. Optical Materials Only - leave blank.

When ordering lenses and/or frames, complete Form 2803, Optical Prescription Order. Attach Form HFS 2803 to the Provider Invoice and submit both forms to the Department.

Sections 25 through 30 of the Provider Invoice are to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges.

If an additional third party resource was identified for one or more of the services billed in Service Sections 1 through 6 of the Provider Invoice, complete the TPL fields in accordance with the following instructions:

Conditionally Required

25. Sect. # - If more than one third party made a payment for a particular service, enter the service section number (1 through 6) in which that service is reported.

If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in Section 25C will be applied to the total of all service sections on the Provider Invoice.

Conditionally Required **25A. TPL Code** - Enter the appropriate TPL Code referencing the source of payment (Chapter 100, General Appendix 9). If the TPL Codes are not appropriate, enter 999 and enter the name of the payment source in Section 35.

Conditionally Required **25B. Status** - Enter the appropriate TPL Status Code. See the Status field in Item 23 above, for correct coding of this field.

Conditionally Required **25C. TPL Amount** - Enter the amount of payment received from the third party resource.

Optional **25D. TPL Date** - Enter the date the claim was adjudicated by the third party resource. (See the TPL Date field in Item 23 above, for correct coding of this field.)

Conditionally Required **26. Sect. #** - (See 25 above).

Conditionally Required **26A. TPL Code** – (See 25A above).

Conditionally Required **26B. Status** – (See 25B above).

Conditionally Required **26C. TPL Amount** – (See 25C above)

Conditionally Required **26D. TPL Date** – (See 25D above).

Conditionally Required **27. Sect. #** - (See 25 above).

Conditionally Required **27A. TPL Code** – (See 25A above).

Conditionally Required **27B. Status** – (See 25B above).

Conditionally Required **27C. TPL Amount** – (See 25C above)

Conditionally Required **27D. TPL Date** – (See 25D above).

Claim Summary Fields: The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are located at the bottom far right of the form.

Required	**28.**	**Tot Charge** - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 6.
Required	**29.**	**Tot Deductions** - Enter the sum of all payments submitted in the TPL Amount field in Service Sections 1 through 6. If no payment was received, enter zeroes (0 00).
Required	**30.**	**Net Charges** - Enter the difference between Total Charge and Total Deductions.
Required	**31.**	**# Sects** - Enter the total number of service sections completed in the top part of the form. This entry must be at least one, and no more than 6. Do not count any sections that were deleted because of errors.
Not Required	32.	Original DCN - Leave blank.
Not Required	33.	Sect. – Leave blank.
Not Required	34.	Bill Type – Leave blank.
Conditionally Required	**35.**	**Uncoded TPL Name** - Enter the name of the third party resource. The name must be entered if TPL code 999 is used.
Required	**36-37**	**Provider Certification, Signature and Date** - After reading the certification statement, the provider or their designee must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned Provider Invoices will be rejected. The signature date is to be entered in MMDDYY format.

MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

Routine claims, including those with an Optical Prescription Order attached, are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or HFS 2432 Split Billing Transmittal) are to be mailed to the Department in pre-addressed mailing envelope, Form 2248, NIPS Special Invoice Handling Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Forms Requisition:

Billing forms may be requested on our Web site at: http://www.hfs.illinois.gov/forms/ or by submitting a 1517, as explained in Chapter 100, General Appendix 10.

APPENDIX O-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM HFS 1409, PRIOR APPROVAL REQUEST

Form HFS 1409, Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in the Optometric Fee Schedule, on the Department's Web site

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Conditionally Required	=	Entries that are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable; leave blank.

COMPLETION		**ITEM EXPLANATION AND INSTRUCTIONS**
Required	**1.**	**Recipient ID Number** – Enter the nine-digit recipient number assigned to the patient for whom the service or item is requested. This number is found to the right of the patient's name on the back of the Medical Programs card.
Required	**2.**	**Recipient Name –** Enter the name of the patient for whom the service or item is requested.
Required	**3.**	**Birth date** – Enter the patient's birth date.

Required	**4.**	**Provider/NPI # -** Enter the provider number or NPI number as shown on the Provider Information Sheet.
Required	**5.**	**Provider Telephone # -** Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.
Required	**6.**	**Provider Name –** Enter the name of the provider who will provide the service or item.
Required	**7.**	**Physician Name –** Enter the name of the optometrist or physician who signed the order or prescription recommending that the patient receive the specific item or service.
Required	**8.**	**Provider Street Address –** Enter the address of the provider.
Required	**9.**	**Physician Street Address –** Enter the address of the ordering practitioner
	10.	**Provider City, State, ZIP Code –** Enter the address of the provider
Required	**11.**	**Physician City, State, ZIP Code –** Enter the address of the ordering practitioner
Required	**12.**	**Diagnosis Code –** Enter the ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code that corresponds to the description listed in item 14 below.
Conditionally Required	**13.**	**Additional Diagnosis –** Enter the additional ICD-9-CM, or upon implementation, ICD-10-CM diagnosis codes, if applicable.
Required	**14.**	**Diagnosis Description –** Enter the written description, which corresponds with the diagnosis code listed in item 12.
Not Required	15.	Patient Height/Weight

Required **16.** **Procedure Code –** Enter the five-digit HCPCS or CPT code that identifies the specific item/service being requested.

Description – Briefly describe the services or items or materials to be provided.

QTY – Enter the number of items to be dispensed in the time period covered by the prior approval request or enter the number of times the service is to be performed.

CAT. SERV – Enter the two-digit category of service (COS) code corresponding to the related item/service. Valid entries are:
01 Physician Services
45 Optical Supplies

Prov Charge – Enter the total amount to be charged for the item being requested.

Approved HFS Amt – Leave Blank

Begin Date – If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval is granted, leave blank.

End Date - Indicate the ending date of service, if applicable.

Pur/Rent - Leave blank

Mod – To be used for modifiers at a later date.

Conditionally Required **17-20.** To be used for additional procedures. If more than five procedures are listed, another request must be made.

Required **21.** **Additional Medical Necessity –** To be used for other medical information. In addition to a narrative explanation, diagnosis and visual acuity both with and without glasses should be provided.

Not Required 22. Approving Authority Signature

Required **23.** **Provider Signature/Date –** To be signed in ink by the individual who is to provide the service.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The provider is to submit the form to the Department as indicated below. The provider may wish to retain a copy in the provider's records.

The HFS 1409 may be mailed in pre-addressed mailing envelopes, Form HFS 2300, provided by the Department.

Mailing address: Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9105

A notification of approval or denial of the service(s) will be mailed to the provider. The service is not to be provided until the approval notification is received.

Forms Requisition:

The HFS 1409 form is available in a PDF-fillable format on the Department's Web site at: <http://www.hfs.illinois.gov/medicalforms/>. This form and HFS 2300 envelope may also be requested on our Web site at: http://www.hfs.illinois.gov/forms/ or by submitting a 1517, as explained in Chapter 100, General Appendix 10.

APPENDIX O-2a

SPECIAL PRIOR APPROVAL INSTRUCTIONS FOR POLYCARBONATE LENSES FOR ADULTS

The Illinois Department of Corrections' (DOC) eyeglasses laboratory at Dixon, Illinois, has the capability to manufacture polycarbonate lenses. The department will authorize the DOC lab to complete polycarbonate lens orders, instead of authorizing payment to the provider to obtain these lenses from an outside source.

Prior approval is required for polycarbonate lenses for adults, age 21 and older. Providers who request prior approval for polycarbonate lenses for adults must follow the process outlined below. **Polycarbonate lenses for children through age 20 do not require prior approval.**

- The HFS 1409, Prior Approval Request must be completed. Instructions for completing this form can be found in Appendix O-2 of this handbook. HCPCS polycarbonate lens Code V2784 must be the requested procedure code, and the eyeglasses prescription should be listed in Box 28.

- The HFS 1443 Provider Invoice must be completed identifying the procedure code for the dispensing fee, and an optometric examination, if applicable.

- The HFS 2803 Optical Prescription Order (OPO) must be completed **and the checkbox for polycarbonate lenses must be marked.**

All three forms must be submitted to the department together.

If the prior approval request is approved, the OPO will be forwarded to DOC for manufacture of the order, and the claim will be processed. The provider and patient will receive a letter of approval.

If the prior approval request is denied, the provider and the patient will receive a denial letter. The provider will be responsible for explaining to the patient that the department did not approve the polycarbonate material for the lenses. The claim and OPO will be processed, and the eyeglasses will be fabricated without the polycarbonate material.

The patient may choose to purchase polycarbonate lenses through the provider at the patient's expense. If the patient elects to purchase polycarbonate lenses, the provider will arrange for fabrication of those lenses through an optical lab, and the patient will reimburse the provider. Eyeglass frames may still be obtained through the department, even if the patient elects to purchase the lenses from the provider.

If the procedure code for the dispensing fee is rejected because of a billing error on a service that has been prior approved, the provider will need to:

- Resubmit the corrected claim,
- Attach a copy of the prior approval letter,
- Attach the OPO

APPENDIX O-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider, and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date his or her signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic O-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix O-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

FIELD	EXPLANATION
(1) **Provider Key**	This number uniquely identifies the provider, and is used internally by the Department. It is directly linked to the reported NPI shown in Field 8.
(2) **Provider Name And Location**	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state, if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
(3) **Enrollment Specifics**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **Provider Type** is a three-digit code and corresponding narrative that indicates the provider's classification.

Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

Enrollment Status is a one-digit code and corresponding narrative that indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCOST if it appears in this item.

Immediately following the enrollment status indicator are the **Begin** date, indicating when the provider was most recently enrolled in Department's Medical Programs; and the **End** date, indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

Exception Indicator may contain a one-digit code and corresponding narrative, indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested by Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested by Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **Exception Indicator** are the **Begin** date, indicating the first date when the provider's claims are to be manually reviewed; and the **End** date, indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

4 **Certification/ License Number**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date, indicating when the license will expire.

5 **S.S.#**

This is the provider's Social Security or FEIN number.

6 **Specialty and Categories of Service**

This area identifies special licensure information, and the types of services a provider is enrolled to provide.

SPECIALTY CODE is a three-digit code and corresponding narrative verifying that an optometrist has received TPA/DPA certification. An entry in this item is followed by the date that the Department was notified of the certification.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

001 = Physician Services
003 = Optometric Services
045 = Optical Materials

Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **Payee Information**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC** # is the number assigned to the payee by the Medicare Carrier, to cross-over Medicare billable services. The PIN is the number assigned by Medicare to a provider within a group practice, if applicable.

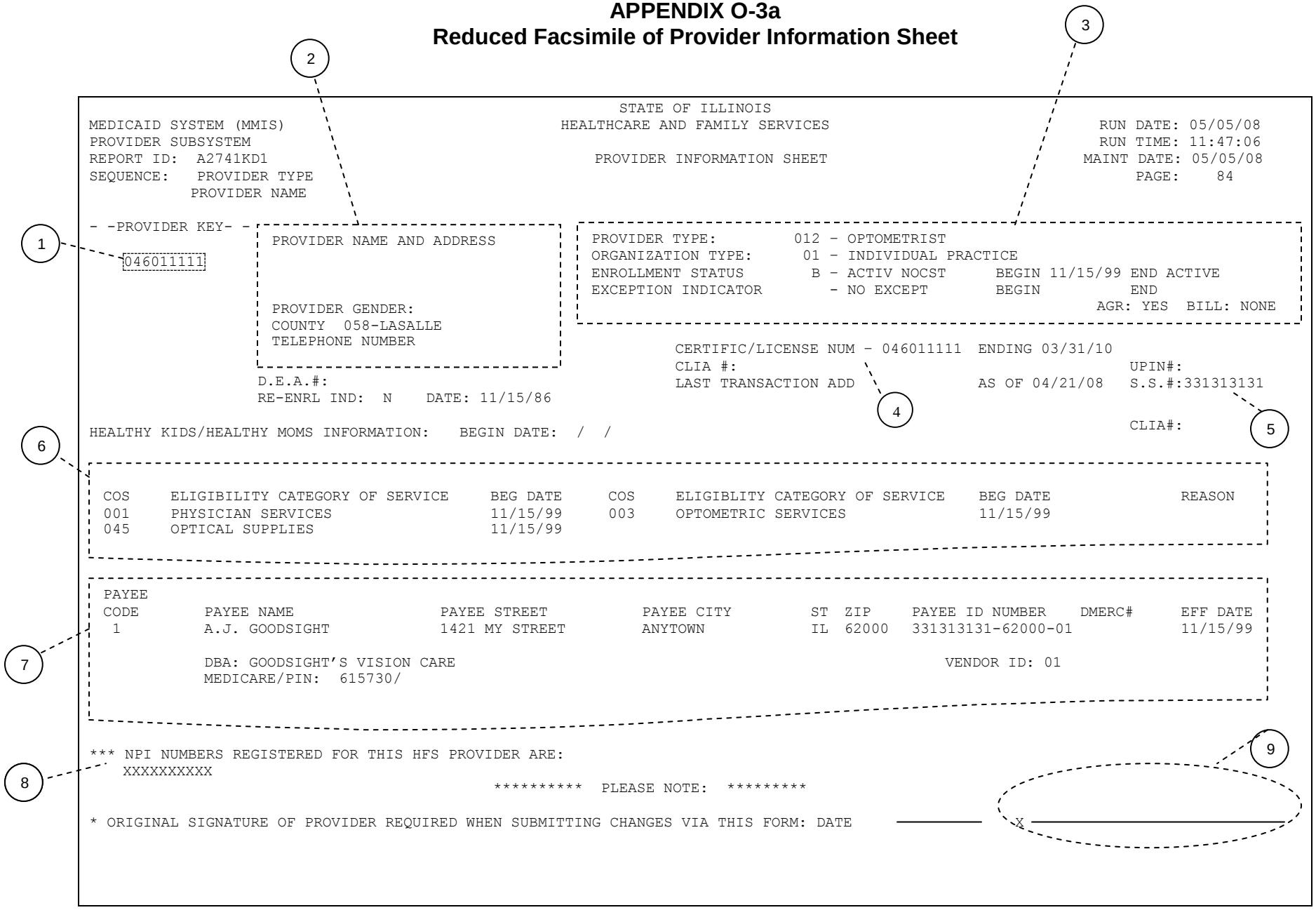
8 **NPI**

The National Provider Identification Number contained in the Department's database.

9 **Signature**

The provider is required to affix an original signature when submitting changes to the Department.

APPENDIX O-3a
Reduced Facsimile of Provider Information Sheet



APPENDIX O-4

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 3797, MEDICARE CROSSOVER INVOICE

To assure the most efficient processing by the Department, please follow these guidelines in the preparation of paper claims for image processing:

- Use original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image and will be returned to the provider.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not alter the document size.
- Attachments containing a black border, as a result of photocopying with the copier cover open, cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- Print in the gray area of attachments, either as part of the original or as a result of photocopying a colored background, is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachment with staples.

Do not attach a copy of the Explanation of Medicare Benefits (EOMB) when billing on the HFS 3797.

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. **If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.**

MediPlan Card – the identification card issued monthly by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago), All Kids Assist or All Kids Moms and Babies, and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration of Medicare coinsurance and deductibles.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department, and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

COMPLETION		ITEM EXPLANATION AND INSTRUCTIONS
Required		**Claim Type** – Enter a capital "X" in the box labeled 23 – Practitioner. This claim type includes physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, and Imaging Centers.
Required	**1.**	**Recipient's Name** - Enter the recipient's name (first, middle, last) exactly as it appears on the back of the MediPlan card.
Required	**2.**	**Recipient's Birth date** - Enter the month, day and year of birth. Use the MMDDYY format.
Required	**3.**	**Recipient's Sex** – Enter a capital "X" in the appropriate box.

Conditionally Required

4. Was Condition Related to –

A. Recipient's Employment - Treatment for an injury or illness that resulted from recipient's employment, enter a capital "X" in the "Yes" box.

B. Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate.

Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9.

Required **5. Recipient's Medicaid Number** – Enter the individual's assigned nine-digit number from the MediPlan Card. Do not use the Case Identification Number.

Required **6. Medicare HIC (Health Insurance Claim) Number** – Enter the Medicare Health Insurance Claim Number (HICN).

Required **7. Recipient's Relation to Insured** – Enter a capital "X" in the appropriate box.

Required **8. Recipient's or Authorized Person's Signature** – The recipient, or authorized representative, must sign and enter a date unless the signature is on file with the provider/supplier. **If the signature is on file, enter the statement, "Signature on File," here**.

Conditionally Required **9. Other Health Insurance Information** - If the recipient has an additional health benefit plan, enter a capital "X" in the "YES" box. Enter Insured's Name, Insurance Plan/Program Name And Policy/Group No., as appropriate.

Required **10A. Date(s) of Service** - Enter the date(s) of service submitted to Medicare. Use MMDDYY format in the "From" and "To" fields.

Required **10B. P.O.S. (Place of Service)** – Enter the two-digit POS code submitted to Medicare.

Required **10C. T.O.S. (Type of Service)** –Refer to the Handbook for Physician Services, Appendix A-1, for a listing of valid TOS codes.

Required	**10D.**	**Days or Units** – Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001. Mileage – Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032. Anesthesia or Assistant Surgery Services– Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001.
Required	**10E.**	**Procedure Code** - Enter the procedure code adjudicated by Medicare shown on the Explanation of Medicare Benefits (EOMB).
Required	**10F**.	**Amount Allowed** – Enter the amount allowed by Medicare for the service(s) provided as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10G.**	**Deductible** – Enter the deductible amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10H.**	**Coinsurance** – Enter the coinsurance amount for service(s) as shown on the Explanation of Medicare Benefits (EOMB).
Required	**10I.**	**Provider Paid** – Enter the amount the provider was paid by Medicare as shown on the Explanation of Medicare Benefits (EOMB).
Conditionally Required	**11.**	**For NDC Use Only** – Required when billing NDC codes for pharmacy/physician claims.
Conditionally Required	**12.**	**For Modifier Use Only** – Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	13A.	Origin of Service –Leave blank.
Not Required	13B.	Modifier – Leave blank.
Not Required	14A.	Destination of Service – Leave blank.
Not Required	14B.	Modifier – Leave blank.

Not Required 15A. Origin of Service – Leave blank.

Not Required 15B. Modifier – Leave blank.

Not Required 16A. Destination of Service – Leave blank.

Not Required 16B. Modifier – Leave blank.

Optional **17. ICN #** - Enter the Medicare Invoice Control Number, Patient Account Number or Provider Reference Number. This field can accommodate up to 20 numbers or letters. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.

Conditionally Required **18. Diagnosis or Nature of Injury or Illness** - Enter the description of the diagnosis, or nature of injury or illness, that describes the condition primarily responsible for the recipient's treatments. A written description is not required if a valid ICD-9-CM, or upon implementation, ICD-10-CM code is entered in Field 18A.

Required **18A. Primary Diagnosis Code** – Enter the valid ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code for the services rendered.

Optional **18B**. **Secondary Diagnosis Code** – A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM, or upon implementation, ICD-10-CM diagnosis code.

Required **19. Medicare Payment Date** – Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). Use MMDDYY format.

Conditionally Required **20. Name and Address of Facility Where Services Rendered** This entry is required when Place of Service (10B) is other than provider's office or recipient's home. Enter the facility name and address where the service(s) was furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word, "Same."

Required **21. Accept Assignment** – The provider must accept assignment of Medicare benefits for services provided to recipients, for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box, if accepting assignment.

Required	**22.**	**Physician/Supplier Name, Address, City, State, ZIP Code**– Enter the physician/supplier name exactly as it appears on the Provider Information Sheet under "Provider Key."
Required	**23.**	**HFS Provider Number** – Enter the Provider's NPI.
Required	**24.**	**Payee Code** – Enter the single-digit number of the payee to whom the payment is to be sent. Payees are coded numerically on the Provider Information Sheet.
Conditionally Required	**25.**	**Name of Referring Physician or Facility** – Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. Referring Physician – a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering Physician – A physician who orders non-physician services for the Recipient such as diagnostic tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.
Conditionally Required	**26.**	**Identification Number of Referring Physician** – This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a physician's order or referral must include the ordering/referring physician's NPI.
Not Required	27.	Medicare Provider ID Number
Required	**28.**	**Taxonomy Code** - Enter the appropriate ten-digit HIPAA Provider Taxonomy code.
Conditionally Required	**29A.**	**TPL Code** – The TPL Code contained on the Recipient's MediPlan Card is to be entered in this field. If payment was received from a third party resource not listed on the MediPlan Card, enter the appropriate TPL Code as listed in Chapter 100, General Appendix 9. If none of the TPL codes in the General Appendix 9 are applicable to the source of payment, enter code "999." If more than one-third party made a payment for a particular service, the additional payment is to be shown in Fields 30A – 30D.

Conditionally Required

29B. TPL Status – If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.
02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.
03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.
04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability.
05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.
06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.
07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.
10 – Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

29C. TPL Amount – Enter the amount of payment received from the third party resource. If there is no TPL amount, enter $0.00. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Conditionally Required

29D. TPL Date – A TPL date is required when any status code is shown in Field 29B. Use the date specified below for the applicable TPL status code. Use the MMDDYY format.

Status Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Conditionally Required

30A. TPL Code – (See 29A above).

Conditionally Required

30B. TPL Status – (See 29B above).

Conditionally Required

30C. TPL Amount – (See 29C above).

Conditionally Required

30D. TPL Date – (See 29D above).

Required

31. Provider Signature - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider. The provider's signature should not enter the date section of this field.

Required

32. Date – The date of the provider's signature is to be entered in the MMDDYY format.

MAILING INSTRUCTIONS

The Medicare Crossover Invoice is a single page or two-part continuous feed form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the Department in the pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department. Should envelopes be unavailable, the HFS 3797 (Medicare Crossover Invoice) can be mailed to:

Medicare Crossover Invoice
Healthcare and Family Services
Post Office Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition - Billing forms may be requested on our Web site at http://www.hfs.illinois.gov/forms/ or by submitting a 1517 as explained in Chapter 100, General Appendix 10.